Casper Children's Dental Clinic

Pediatric Dentistry

*** THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO A BETTER UNDERSTANDING OF YOUR CHILD.**

CHILD'S NAME	SEX	NAME CHILD PREFERS TO BE CALLED	AGE	DATE OF BIRTH / PATIENT SS#

NAME OF SCHOOL (OR) HOME SCHOOL	GRADE	WEIGHT	REASON FOR VISIT
YES ___ NO ___			

REFERRED TO THIS OFFICE BY: (WE WISH TO THANK THEM)

MEDICAL HISTORY

CHILD'S PHYSICIAN / PHONE #	CITY	DATE LAST SAW PHYSICIAN ___/___ MONTH YEAR

	YES	NO
1. Is your child presently under the care of a physician for any medical problem? What? _____	❑	❑
2. Is your child currently taking any medication? What? _____	❑	❑
3. Has your child ever been hospitalized or had surgery? For What? _____ Date: _____	❑	❑
4. Is your child allergic to any food or medicine? What? _____	❑	❑
5. Name of Pharmacist: _____		

Has your child a history of (check one):

- ❑ Heart trouble or murmers
- ❑ Rheumatic fever
- ❑ Allergies
- ❑ Drug sensitivities
- ❑ Other (please specify)
- ❑ Hyperactivity
- ❑ Developmentally Delayed
- ❑ Brain injury
- ❑ Diabetes
- ❑ Asthma
- ❑ Epilepsy
- ❑ Seizures/convulsions
- ❑ Recurrent headaches
- ❑ Lung/breathing problems
- ❑ Hearing
- ❑ Sight
- ❑ Cancer/tumors
- ❑ AIDS/ARC
- ❑ Kidney/liver involvement
- ❑ Hepatitis
- ❑ Bleeding problems
- ❑ Blood disorders
- ❑ Blood transfusions Date_____
- ❑ None

DENTAL HISTORY

Child's First Dental Visit? ❑ Yes ❑ No	Previous Dentist / City	Date Last Visit

Any Injuries to Your Child's Teeth or Jaws? (Falls, Blows, Chips, etc.) ❑ Yes ❑ No	History of? ❑ TMJ Disorders ❑ Grinding ❑ Lip Sucking ❑ Nail Biting ❑ Mouth Breathing ❑ Pacifier ❑ Thumbsucking ❑ Finger Sucking

Has your child experienced any unfavorable reaction from previous medical or dental care? ❑ Yes ❑ No	Explain

How do you think your child will act toward the dentist?

Name of family dentist / City

PREVENTIVE DENTAL HISTORY

How often does your child brush?	Is toothbrushing supervised? ❑ Yes ❑ No	When first baby tooth erupted?

Is dental floss used? ❑ Yes ❑ No	Does your child receive (check) ❑ Flouride in Vitamins ❑ Flouride tablets/drops ❑ Flouridated water ❑ None

Breast fed?	Bottle fed?	To what age?

OVER PLEASE

FAMILY INFORMATION

Mailing Address			City, State, Zip	Phone
Father's Full Name	Social Security No.	Date of Birth	Address if different	Occupation
Employeed by	Business Address		City	Bus. Phone
Mother's Full Name	Social Security No.	Date of Birth	Address if different	Occupation
Employeed by	Business Address		City	Bus. Phone

Has any member of your family been a patient in this office before? ❑ Yes ❑ No If yes, name

In case of emergency, name and address, and phone number of someone who will always know your whereabouts.

Name	Address	Phone

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

Is your child covered by a Dental Insurance Plan?
❑ Yes ❑ No

Name of Parent Insured	Social Security No.	Name of Insurance Company	Group or Policy No.
Is your child eligible for state/county aid? ❑ Yes ❑ No		Address of Insurance Company	

If family not living together, person to be responsible for child's account?

I have received the treatment plan, I authorize release of any information relating to all insurance claims, and I understand that I am responsible for all costs of dental treatment.

Signature of Parent/Guardian	Date

I hereby authorize payment directly to the below named Dentist of the group insurance benefits otherwise payable to me. Date

Signature of Parent/Guardian

I hereby authorize Dr. Roy E. Paulson and/or his associates to perform any and all treatment for my above named child and consent to such methods, medications, and agents as my be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled by either party. I will be responsible for the cost of this dental care. In the event that the amounts due and owing are not paid, a monthly finance charge of 1.75% will be assess on all unpaid accounts 60 days past service date. If this matter is turned over for collection, I will be responsible for all costs and attorney fees.

Signature of Parent/Guardian	Date